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A response to McCambridge and Rollnick (2013)

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McCambridge and Rollnick (1) argue that increased benefits from brief motivational interventions (MIs) for alcohol abuse may be obtained if they more directly addressed patients' concerns, especially in severe dependence and primary care. We agree, but take the idea a step further.

Recent research on comorbidity has illustrated the power of simultaneously addressing multiple issues in an integrated manner, especially when these changes have synergistic effects (as typically occurs with psychosis and substance use (2)). Integrated MI for comorbidity can even be used productively in a single-session format (3). This idea may have wider application. Recent work in remote Indigenous Australian communities has highlighted the benefits of a broad-ranging discussion of key relationships, activities and resources that confer strength, as well as aspects that worry them or cause dissatisfaction (4). If excessive drinking is present, its impact on other life areas is reviewed, as in standard MI. However, it is considered alongside other highly valued goals. While the approach has demonstrated effects on both alcohol use and mental health (5), its impact is only restricted by the range of goals that are selected.

MIs for excessive drinking have always encouraged a wide-ranging audit of ways that alcohol has affected the person's life, and these discussions often identify additional goals that may later be addressed. The Indigenous and comorbidity examples highlight potential advantages of adopting the person's own priorities, and supporting simultaneous adoption of more than one behavioural goal. We contend that people can successfully pursue multiple goals without overwhelming their coping resources, especially if they are unified by a coherent and highly valued objective, such as 'becoming healthy'. Explicitly embedding

alcohol control within a broader objective allows drinking to be addressed with reduced stigma. Simultaneous efforts to address multiple concerns often also encompasses emotional and contextual triggers for excessive drinking as well as problems it has previously caused (1). Supporting an individual's commitment to valued functional objectives is highly consistent with the spirit of MI. We contend that the relative impact of a sole focus on alcohol versus a broader personal change agenda should be more systematically examined in research.

The current status of MI—both in primary care and in other settings—raises other issues. As McCambridge and Rollnick note, sustained average effects of brief interventions are small, especially in severe dependence (6, 7). Why might this be?

Among other reasons, MIs may not sufficiently transfer to habitual behaviours in everyday life. While core values and past successes are typically rehearsed in sessions, training MI as a self-management skill is not standard. Maintaining routine use of MI strategies in temptation situations may require cueing, by association with frequent behaviors or other reminders, until it becomes habitual. Thematic applications of MI elements in primary care consultations offer further opportunities to consolidate its use by patients. When MIs are solely focused on initial engagement in change, expected advantages to change are essentially hypothetical, and recalled successes may not be recent or convincing. Emphasising actual successes and improvements in repeated consultations may refresh and help maintain MIs' effects.

Further benefits from MIs may be obtained if they apply recent advances in the understanding of motivation and desire (8-11), which emphasize the importance of multisensory imagery. Elaboration of dysfunctional imagery is impeded and craving attenuated by concurrent visuospatial tasks, including other imagery (12). Conversely,

functional desires can be strengthened using imagery (12), and imagery adds to the behavioural impact of action plans or implementation intentions (13). An imagery-based approach to supporting behavior change also encourages covert rehearsal of coping strategies (14), using imagery for problem solving, and replaying memories of successful alcohol control in the past.

Based on the above considerations, we have developed a new motivational intervention, Functional Imagery Training (FIT), which applies the format and spirit of MI, but uses imagery throughout, and encourages the development of self-management skills, whose use is cued in brief ongoing contacts and by pairing with a frequent behaviour. Participants take photos or select pictures from online libraries to remind them of improvements and successes in control, and progress graphs of successful control offer additional material for productive imagery. Pilot trials on its effects on alcohol misuse and other behavioural goals are currently underway.

We agree with McCambridge and Rollnick that additional focus is needed on addressing patients' functional problems in brief MIs for excessive drinking. Even greater impact may be achieved by training motivational approaches as self-management skills, generating vivid imagery about improved futures, training people to incorporate imagery practice into their daily routines, and rehearsing imagery in brief repeated contacts. We see these strategies as highly compatible with primary care and with patients' priorities, and expect their application to result in stronger and more sustained changes across the spectrum of hazardous and dependent drinking.

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